2009 Evidence of Coverage

January 1, 2009

Your Medicare Advantage health benefits and services as a member of the State of Michigan's Medicare Plus Blue Group Plan

Medicare PLUS Blue Group℠

Blue Cross Blue Shield of Michigan

Medicare Plus Blue Group is a private fee-for-service plan with a Medicare contract. Medicare Plus Blue Group is issued by Blue Cross Blue Shield of Michigan, a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

State of Michigan

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Welcome

Dear State of Michigan Medicare Plus Blue Group Member:

Welcome to Medicare Plus Blue Group, your Medicare Advantage plan. Blue Cross Blue Shield of Michigan contracts with the federal government and continues to administer your benefits on behalf of the State Health Plan.

This Evidence of Coverage booklet gives the details about your Medicare Advantage coverage and explains how to receive the care you need. This booklet is an important document. Please keep it in a safe place.

This EOC supplements Your Benefit Guide that summarizes your health care benefits. If this EOC conflicts with Your Benefit Guide in any manner, this EOC will govern. Your Annual Notice of Change, which outlines the changes to your benefit plan, was provided in the Michigan Civil Service Commission's Retiree Benefits Bulletins GIS 01-2008R and GIS 02-2008R. Please refer to these bulletins for the plan changes, effective January 1, 2009.

If you have any questions regarding Medicare Plus Blue Group, please call Member Services at 888-322-5557, Monday through Friday from 8:30 a.m. to 5:00 p.m., EST. TTY users should call 800-579-0235.

We wish you good health.

Arva Overton
BCBSM Account Manager
State of Michigan Account

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1. Introduction

This is your Evidence of Coverage (EOC), which explains how to receive your Medicare health care through our plan, Medicare Plus Blue Group, a Medicare Advantage Private-Fee-For-Service.

This EOC is our summary for you. The EOC explains your rights, benefits, and responsibilities as a member of our plan and is in effect January 1, 2009.

This EOC will explain to you:

- What is and is not covered by our plan.
- How to receive the care you need, including some rules you must follow.
- What your out-of-pocket costs will be.
- How to file a complaint/grievance and appeal.
- How to discontinue coverage.

2. Eligibility requirements

To be a member of our plan you must be enrolled in Medicare Parts A and B. If you currently pay a premium for Medicare Part A or Part B, you must continue paying your premiums.

Plan membership card

While you are a member of our plan, you must use our membership card for services. Do not use your red, white, and blue Medicare card. Keep it in a safe place.

Please carry your Medicare Plus Blue Group membership card at all times and remember to show your card when you receive services. If your membership card is damaged, lost, or stolen, call Member Services at 888-322-5557 and we will send you a new card.

Remember, you have a separate membership card for your vision care plan.

Important information on keeping membership up-to-date

You may be required to complete a Verification of Coverage survey so that we can know what other health coverage you have besides our plan. Medicare requires us to collect this information from you, so when you receive the survey, please complete and return it to Blue Cross Blue Shield of Michigan (BCBSM).
If you have additional health coverage, you must provide that information to our plan. In addition, if you lose or gain additional health coverage, please call Member Services at 888-322-5557 to update your membership records.

3. How you receive care

Providers you can use to receive services covered by our plan

As a member of our plan, you may receive health care services from any provider, such as a doctor or hospital, in the United States who is eligible to be paid by Medicare and agrees to accept Medicare Plus Blue Group's terms and conditions of payment prior to providing health care services to you. Not all providers may accept our plan's payment terms or agree to treat you. Therefore, you must show your plan ID card every time you visit a health care provider so that the provider is aware that you are in a Private-Fee-For-Service plan. There is a telephone number and Web site on the card for the provider to find out about our plan's terms and conditions of payment. This gives your provider the right to choose whether to accept our plan's terms and conditions of payment before treating you. The provider cannot change his/her mind about accepting the plan's terms and conditions of payment after providing services. If you need emergency care, it is covered whether the provider agrees to accept the plan's payment terms and conditions or not.

See the benefits chart in Section 12 for a summary of covered services.

If your provider agrees to accept our plan, then the provider must follow the plan's terms and conditions of payment, and bill the plan for the services they provide for you. You are only required to pay the copayment or coinsurance amount allowed by our plan at the time of the visit. A provider can decide at every visit whether or not to accept our plan's payment terms and conditions.

As soon as you have told your provider that you are a member of our plan (for example, by showing them your plan ID card) and they agree to treat you, your provider is bound by the terms and conditions of payment of the plan even if they do not explicitly accept them. We call these providers "deemed providers."

If your provider does not agree to our plan's terms and conditions of payment, then the provider should not provide services to you, except for emergencies. In this case, you will need to find another provider that will accept our plan's payment terms and conditions.

What should you do with your provider bills?

You should only pay the provider the cost-sharing allowed by our plan and listed in Section 12. You should ask your provider to bill us for the rest of the fee and we will pay the provider according to our plan's terms and conditions of payment. If the provider asks you to pay the full amount of the bill, and have you reimbursed by the plan, tell the provider that you only have to pay the cost-sharing amount. Your membership card in our plan will indicate how the provider can contact us for information on our terms and conditions of payment. If the provider wants further information on payment for covered services, please have them contact Provider Services at 866-309-1719.

If you receive a bill for the services, you may send the bill to us for payment. We will pay your provider for our share of the bill and will let you know if you must pay any cost-sharing. However, if you have already paid for the covered services we will reimburse you for our share of the cost.

If you have any questions about whether our plan will pay for a certain health care service, you can ask us for a written advance coverage decision before you receive the service. We will let you know if our plan will pay for the service.

Receiving care if you have a medical emergency or an urgent need for care

What is a "medical emergency"?

A "medical emergency" is when you believe your health is in serious danger. A medical emergency includes severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

What is covered if you have a medical emergency?

You may receive covered emergency medical care whenever you need it, anywhere in the United States. Ambulance services are covered in situations where other means of transportation in the United States would endanger your health. (See the benefits chart in Section 12 for more detailed information.)

What if it was not a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—and the doctor may say that it was not a medical emergency after all. If you decide to receive follow-up care from the provider treating you, then you should advise them of your plan enrollment as soon as possible, for example by showing them your member ID card with your plan information. The plan will pay for all medically necessary plan covered services provided by the provider and non-emergency care that you receive from any provider in the United States whom you have informed, by showing your member ID card, that you are a plan member, and who agrees to accept our plan's terms and conditions of payment.

What is your cost for services that are not covered by our plan?

Our plan covers all of the medically-necessary services that are covered under Medicare Part A and Part B. Our plan uses Medicare's coverage rules to decide what services are medically necessary. You are responsible for paying the full cost of services that are not covered by our plan. Other sections of this booklet describe the services that are covered under our plan and the rules that apply to receiving your care as a plan member.

If you need a service that our plan decides is not medically necessary based on Medicare's coverage rules, you may have to pay all of the costs of the service if you did not ask for an advance coverage determination. However, you have the right to appeal the decision.

If you have any questions about whether our plan will pay for a service or item, including inpatient hospital services, you have the right to have a coverage determination made for the service. You may call Member Services at 888-322-5557 and tell us you would like a decision on whether the service will be covered before you receive the service.

For covered services that have a benefit maximum such as transplant care, you have to pay the full cost of any services you receive beyond the maximum. Paying for these costs will not count toward your out-of-pocket maximum. You can call Members Services at 888-322-5557 when you want to know how much of your benefit maximum you have already used.

How can you participate in a clinical trial?

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. A clinical trial is one of the final stages of a research process that helps doctors and researchers see if a new approach works and if it is safe.

Specified oncology clinical trials cover antineoplastic drugs for the treatment of stages II and III breast cancer and all stages of ovarian cancer when they are provided following an approved phase II or III clinical trial.

This benefit does not limit or preclude coverage of antineoplastic drugs when Michigan law requires these drugs, and the reasonable cost of their administration, be covered. Payment is determined by services provided.

For services to be covered, the following requirements must be met:

- The inpatient admission and length of stay must be medically necessary and preapproved. No retroactive approvals will be granted.
- The services must be performed at a National Cancer Institute (NCI)-designated cancer center or an affiliate of an NCI-designated center.
- The treatment plan, also called "protocol," must meet the guidelines of the February 19, 1993, American Society of Clinical Oncology statement for clinical trials.
- The patient must be an eligible BCBSM member with hospital, medical and surgical coverage.

If these requirements are not met, the services will not be covered and you will be responsible for all charges.

Please call Member Services at 888-322-5557 for additional information on specified oncology clinical trials.

You may view or download the publication "Medicare and Clinical Trials" at **medicare.gov** under "Search Tools" select "Find a Medicare Publication," or call 800-MEDICARE (800-633-4227).

4. Your rights and responsibilities as a member of our plan

Introduction to your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of our plan and we explain what you can do if you think you are being treated unfairly or your rights are not being respected.

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Member Services at 888-322-5557. Member Services can also help if you need to file a complaint about access (such as wheelchair access). You may also call the Office of Civil Rights at 800-368-1019. TTY/TDD users should call 800-537-7697, or your local Office of Civil Rights.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must receive written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to receiving information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. You have the right to look at medical records held by the plan, and to receive a copy of your records. There may be a fee charged for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will review your request and figure out whether the changes are appropriate. You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services at 888-322-5557.

Your right to see plan providers, and receive covered services within a reasonable period of time

You will receive most or all of your care from providers you selected, who have agreed to treat you under Medicare Plus Blue Group's terms and conditions of payment. You have the right to seek care from any provider in the United States who is eligible to be paid by Medicare and accepts Medicare Plus Blue Group's terms and conditions of payment.

"Timely access" means you can get appointments and services within a reasonable amount of time.

Your right to know your treatment options and participate in decisions about your health care

You have the right to receive full information from your providers when you go for medical care and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination or a coverage determination.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives.

If you want to have an advance directive, you can obtain a form from your lawyer, a social worker, or some office supply stores. You can sometimes obtain advance directive forms from organizations that give people information about Medicare. Regardless of where you obtain this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you cannot. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe a doctor or hospital has not followed the instructions in it, you may file a complaint with:

Michigan Department of Community Health
Capitol View Building
201 Townsend St.
Lansing, MI 48013
517-373-3740 TTY users should call 517-373-3573

Your right to receive information in other formats

You have the right to have your questions answered. Our plan must have individuals and translation services available to answer questions from non-English speaking beneficiaries, and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of disability. If you have difficulty obtaining information from your plan based on language or a disability, call 800-MEDICARE (800-633-4227).

Your right to information about your costs

You have the right to an explanation from us about any medical care or service not covered by our plan. We must tell you in writing why we will not pay for or approve a service, and how you can file an appeal to ask us to change this decision. See Section 6 for more information about filing an appeal. You also have the right to this explanation even if you obtain the care or service from a provider not affiliated with our organization.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. See Section 5 and Section 6 for more information about complaints. If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to receive a summary of information about the appeals and grievances that members have filed against our plan in the past. To obtain this information, call Member Services at 888-322-5557.

How to obtain more information about your rights

If you have questions or concerns about your rights and protections, you can

- Call Member Services at 888-322-5557.
- Receive free help and information from your State Health Insurance Assistance Program (SHIP). Contact information for your SHIP is in Section 9 of this booklet.
- Visit **medicare.gov** to view or download the publication "Your Medicare Rights & Protections."
- Call 800-MEDICARE (800-633-4227).

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, you may call 888-322-5557 or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office of Civil Rights at 800-368-1019 or TTY/TDD users should call 800-537-7697, or call your local Office of Civil Rights.
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also receive help from your SHIP.

Your responsibilities as a member of our plan include:

- Becoming familiar with your coverage and the rules you must follow to receive care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Call Member Services at 888-322-5557 if you have questions.
- Using all of your insurance coverage. If you have additional health insurance coverage besides our plan, it is important that you use your other coverage in combination with your coverage as a member of our plan to pay your health care expenses. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you.
- **You are required to tell our plan if you have additional health insurance.** Call Member Services at 888-322-5557.
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Medicare Plus Blue Group plan and you must present your plan enrollment card to the provider each time you visit a provider.
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree on. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- Paying your coinsurance or copayment for your covered services. You must pay for services that are not covered.
- If you move outside of our plan service area of the United States and its territories, you cannot remain a member of the State of Michigan's Medicare Plus Blue Group Plan.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services at 888-322-5557.

5. How to file a grievance

What is a grievance?

A grievance is any complaint, other than one that involves a request for an initial determination or an appeal as described in Section 6 of this manual.

Grievances do not involve problems related to approving or paying for Medicare Plus Blue Group medical care or services, problems about having to leave the hospital too soon, and problems about having Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

If we will not pay for or give you the Medicare Plus Blue Group medical care or services you want, or you believe that you are being released from the hospital or SNF too soon, or your HHA or CORF services are ending too soon, you must follow the rules outlined in Section 6.

What types of problems might lead to filing a grievance?

- Problems with the service you receive from Member Services.
- If you feel that you are being encouraged to leave (disenroll from) the plan.
- If you disagree with our decision not to give you a "fast" decision or a "fast" appeal. We discuss these fast decisions and appeals in Section 6.
- We do not give you a decision within the required time frame.
- We do not give you required notices.
- You believe our notices and other written materials are hard to understand.
- Problems with the quality of the medical care or services you receive, including quality of care during a hospital stay.
- Problems with how long you have to wait on the phone, in the waiting room, or in the exam room.
- Problems obtaining appointments when you need them, or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance."

Who may file a grievance

You or someone you name may file a grievance. The person you name would be your "representative." You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the Court or in accordance with State law to act for you. If you want someone to act for you who is not already authorized by the Court or under State law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Member Services at 888-322-5557.

Filing a grievance with our plan

If you have a complaint, you or your representative may call the phone number for **Medicare Plus Blue Group Grievances** (for complaints about Medicare Plus Blue Group medical care or services) in Section 9. We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints.**

Please contact Member Services at 888-322-5557. TTY users should call 800-579-0235. Grievances can be submitted by phone from 8:30 a.m. to 5:00 p.m. EST, Monday through Friday, or in writing to:

Grievance Dept.
BCBSM Medicare Advantage
600 E. Lafayette Blvd. – Mail Code X509
Detroit, MI 48226-2998

The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

Fast grievances

In certain cases, you have the right to ask for a "fast grievance," meaning we will answer your grievance within 24 hours. We discuss situations where you may request a fast grievance in Section 6.

For quality of care problems, you may also complain to the Quality Improvement Organization (QIO)

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to the QIO, or both. If you file with the QIO, we must help the QIO resolve the complaint. See Section 9 for more information about the QIO and for the name and phone number of the QIO in your state.

6. Complaints and appeals about your Medicare Plus Blue Group medical care and service(s)

Introduction

This section explains how you ask for coverage of your Medicare Plus Blue Group medical care or service(s) or payments in different situations. This section also explains how to make complaints when you think you are being asked to leave the hospital too soon, or you think your Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon. These types of requests and complaints are discussed below in Part 1, Part 2, or Part 3.

Other complaints that do not involve the types of requests or complaints discussed below in Part 1, Part 2, or Part 3 are considered **grievances**. You would file a grievance if you have any type of problem with us or one of our network providers that does not relate to coverage for Medicare Plus Blue Group medical care or services. For more information about grievances, see Section 5.

Part 1. Requests for Medicare Plus Blue Group medical care or services or payments.

Part 2. Complaints if you think you are asked to leave the hospital too soon.

Part 3. Complaints if you think your SNF, HHA or CORF services are ending too soon.

PART 1. Requests for medical care, services or payment

This part explains what you can do if you have problems receiving the Medicare Plus Blue Group medical care or service you request or payment (including the amount you paid) for a Medicare Plus Blue Group medical care or service you already received.

If you have problems receiving the Medicare Plus Blue Group medical care or services you need, or payment for a Medicare Plus Blue Group service you already received, you must request an initial determination with the plan.

Initial determinations

The initial determination we make is the starting point for dealing with requests you may have about covering a Medicare Plus Blue Group medical care or service you need, or paying for a Medicare Plus Blue Group medical care or service you already received. Initial decisions about Medicare Plus Blue Group medical care or services are called organization determinations. With this decision, we explain whether we will provide the Medicare Plus Blue Group medical care or service you are requesting, or pay for the Medicare Plus Blue Group medical care or service you already received.

The following are examples of requests for initial determinations:

- You are not receiving Medicare Plus Blue Group medical care or services you want, and you believe that this care is covered by the plan.
- We will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the plan.
- You are being told that a medical treatment or service you have been receiving will be reduced or stopped, and you believe that this could harm your health.
- You have received Medicare Plus Blue Group medical care or services that you believe should be covered by the plan, but we have refused to pay for this care.

Who may ask for an initial determination?

You, your prescribing physician, or someone you name may ask us for an initial determination. The person you name would be your "appointed representative." You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you who is not already authorized under State law, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. If you are requesting Medicare Plus Blue Group medical care or services, this statement must be sent to us at the address or fax number listed under "**Medicare Plus Blue Group Organization Determinations**" in Section 9. To learn how to name your appointed representative, you may call Member Services at 888-322-5557.

You also have the right to have a lawyer act for you. You may contact your own lawyer, or receive the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Asking for a "standard" or "fast" initial determination

A decision about whether we will give you, or pay for, the Medicare Plus Blue Group medical care or service you are requesting can be a "standard" decision that is made within the standard time frame, or it can be a "fast" decision that is made more quickly. A fast decision is also called an "expedited" decision.

Asking for a standard decision

To ask for a standard decision for a Medicare Plus Blue Group medical care or service you, your doctor, or your representative should call, fax, or write us at the numbers or address listed under **Medicare Plus Blue Group Organization Determinations** (for appeals about Medicare Plus Blue Group medical care or services) in Section 9.

Asking for a fast decision

You may ask for a fast decision only if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for benefits that you have not yet received. You cannot receive a fast decision if you are asking us to reimburse you for a benefit that you already received.)

If you are requesting a Medicare Plus Blue Group medical care or service that you have not yet received, you, your doctor, or your representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed under **Medicare Plus Blue Group Organization Determinations** (for appeals about Medicare Plus Blue Group medical care or services) in Section 9.

Be sure to ask for a "fast" or "expedited" review. If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you receive a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast initial determination, we will give you a standard decision.

What happens when you request an initial determination?

- For a decision about payment for Medicare Plus Blue Group medical care or services you already received.

  If we do not need more information to make a decision, we have up to 30 days to make a decision after we receive your request, although a small number of decisions may take longer. However, if we need more information to make a decision, we have up to 60 days from the date of the receipt of your request to make a decision. You will be told in writing when we make a decision.

  If you have not received an answer from us within 60 days of your request, you have the right to appeal.

- For a standard decision about Medicare Plus Blue Group medical care or services you have not yet received.

  We have 14 days to make a decision after we receive your request. However, we can take up to 14 more days if you ask for additional time, or if we need more information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a "fast grievance."

  If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

- For a fast decision about Medicare Plus Blue Group medical care or services you have not yet received.

  If you receive a "fast" decision, we will give you our decision about your requested medical care or services within 72 hours after we receive the request. However, we can take up to 14 more days if we find that some information is missing that may benefit you, or if you need more time to prepare for this review. If we take additional days, we will notify you in writing. If you believe that we should not take any extra days, you can file a fast grievance. We will call you as soon as we make the decision.

  If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a "fast grievance." For more information about fast grievances, see Section 5.

What happens if we decide completely in your favor?

- For a decision about payment for Medicare Plus Blue Group medical care or services you already received.

  Generally, we must send payment no later than 30 days after we receive your request, although a small number of decisions may take up to 60 days. If we need more information to make a decision, we have up to 60 days from the date of the receipt of your request to make payment.

- For a standard decision about Medicare Plus Blue Group medical care or services you have not yet received.

  We must authorize or provide your requested care within 14 days of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

- For a fast decision about Medicare Plus Blue Group medical care or services you have not yet received.

  We must authorize or provide your requested care within 72 hours of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

What happens if we decide against you?

If we decide against you, we will send you a written decision explaining why we denied your request. If an initial determination does not give you all that you requested, you have the right to appeal the decision. (See Appeal Level 1.)

Appeal Level 1: Appeal to the plan

You may ask us to review our initial determination, even if only part of our decision is not what you requested. An appeal to the plan about Medicare Plus Blue Group medical care or services is also called a plan "**reconsideration**." When we receive your request to review the initial determination, we give the request to people at our organization who were not involved in making the initial determination. This helps ensure that we will give your request a fresh look.

Who may file your appeal of the initial determination?

If you are appealing an initial decision about Medicare Plus Blue Group medical care or services, the rules about who may file an appeal are the same as the rules about who may ask for an organization determination. Follow the instructions under "Who may ask for an initial determination?" However, providers who do not have a contract with the plan may also appeal a payment decision as long as the provider signs a "waiver of payment" statement saying it will not ask you to pay for the Medicare Plus Blue Group medical care or service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

You must file the appeal request within 60 calendar days from the date included on the notice of our initial determination. We may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1. **Asking for a standard appeal**

   To ask for a standard appeal about a Medicare Plus Blue Group medical care or service a signed, written appeal request must be sent to the address listed under **Medicare Plus Blue Group Grievance and Appeals** (for appeals about medical care or services) in Section 9.

   You may also ask for a standard appeal by calling us at the phone number shown under **Medicare Plus Blue Group Grievance and Appeals** (for appeals about Medicare Plus Blue Group medical care or services) in Section 8.

2. **Asking for a fast appeal**

   If you are appealing a decision we made about giving you a Medicare Plus Blue Group medical care or service that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast initial determination. You, your doctor, or your representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under **Medicare Plus Blue Group Grievance and Appeals** (for appeals about Medicare Plus Blue Group medical care or services) in Section 9.

Be sure to ask for a "fast" or "expedited" review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal. If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you receive a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance" if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 5). If we deny your request for a fast appeal, we will give you a standard appeal.

Obtaining information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you or your representative. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to receive your doctor's records or opinion to help support your request. You may need to give the doctor a written request to receive information.

You may give us your additional information to support your appeal by calling, faxing, or writing us at the numbers or address listed under **Medicare Plus Blue Group Grievance and Appeals** (for appeals about Medicare Plus Blue Group medical care or services) in Section 9.

You may also deliver additional information in person to the address listed under **Medicare Plus Blue Group Grievance and Appeals** (for appeals about Medicare Plus Blue Group medical care or services) in Section 9.

You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed under **Medicare Plus Blue Group Grievance and Appeals** (for appeals about Medicare Plus Blue Group medical care or services) in Section 9. We are allowed to charge a fee for copying and sending this information to you.

How soon must we decide on your appeal?

- For a decision about payment for Medicare Plus Blue Group medical care or services you already received.

  After we receive your appeal request, we have 60 days to decide. If we do not decide within 60 days, your appeal automatically goes to Appeal Level 2.

- For a standard decision about Medicare Plus Blue Group medical care or services you have not yet received.

  After we receive your appeal, we have 30 days to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

- For a fast decision about Medicare Plus Blue Group medical care or services you have not yet received.

  After we receive your appeal, we have 72 hours to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a decision about payment for Medicare Plus Blue Group medical care or services you already received.

  We must pay within 60 days of receiving your appeal request.

- For a standard decision about Medicare Plus Blue Group medical care or services you have not yet received.

  We must authorize or provide your requested care within 30 days of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

- For a fast decision about Medicare Plus Blue Group medical care or services you have not yet received.

  We must authorize or provide your requested care within 72 hours of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

Appeal Level 2: Independent Review Entity (IRE)

At the second level of appeal, your appeal is reviewed by an outside, Independent Review Entity (IRE) that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The IRE has no connection to us. You have the right to ask us for a copy of your case file that we sent to this entity. We are allowed to charge you a fee for copying and sending this information to you.

How to file your appeal

If you asked for Medicare Plus Blue Group medical care or services, or payment for Medicare Plus Blue Group medical care or services, and we did not rule completely in your favor at Appeal Level 1, your appeal is automatically sent to the IRE.

How soon must the IRE decide?

The IRE has the same amount of time to make its decision as the plan had at **Appeal Level 1**.

If the IRE decides completely in your favor:

The IRE will tell you in writing about its decision and the reasons for it.

- For a decision about payment for Medicare Plus Blue Group medical care or services you already received.

  We must pay within 30 days after we receive notice reversing our decision.

- For a standard decision about Medicare Plus Blue Group medical care or services you have not yet received.

  We must authorize your requested Medicare Plus Blue Group medical care or service within 72 hours, or provide it to you within 14 days after we receive notice reversing our decision.

- For a fast decision about Medicare Plus Blue Group medical care or services.

  We must authorize or provide your requested Medicare Plus Blue Group medical care or services within 72 hours after we receive notice reversing our decision.

Appeal Level 3: Administrative Law Judge (ALJ)

If the IRE does not rule completely in your favor, you or your representative may ask for a review by an Administrative Law Judge (ALJ) if the dollar value of the Medicare Plus Blue Group medical care or service you asked for meets the minimum requirement provided in the IRE's decision. During the ALJ review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel.

How to file your appeal

The request must be filed with an ALJ within 60 calendar days of the date you were notified of the decision made by the IRE (Appeal Level 2). The ALJ may give you more time if you have a good reason for missing the deadline. The decision you receive from the IRE will tell you how to file this appeal, including who can file it.

The ALJ will not review your appeal if the dollar value of the requested Medicare Plus Blue Group medical care or service does not meet the minimum requirement specified in the IRE's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How soon will the Judge make a decision?

The ALJ will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" for information about what we must do if our decision denying what you asked for is reversed by an ALJ.

Appeal Level 4: Medicare Appeals Council (MAC)

If the ALJ does not rule completely in your favor, you or your representative may ask for a review by the MAC.

How to file your appeal

The request must be filed with the MAC within 60 calendar days of the date you were notified of the decision made by the ALJ (Appeal Level 3). The MAC may give you more time if you have a good reason for missing the deadline. The decision you receive from the ALJ will tell you how to file this appeal, including who can file it.

How soon will the Council make a decision?

The MAC will first decide whether to review your case (it does not review every case it receives). If the MAC reviews your case, it will make a decision as soon as possible. If it decides not to review your case, you may request a review by a Federal Court Judge (see Appeal Level 5). The MAC will issue a written notice explaining any decision it makes. The notice will tell you how to request a review by a Federal Court Judge.

If the Council decides in your favor:

See the following section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" for information about what we must do if our decision denying what you asked for is reversed by the MAC.

Appeal Level 5: Federal Court

You have the right to continue your appeal by asking a Federal Court Judge to review your case if the amount involved meets the minimum requirement specified in the MAC's decision, you received a decision from the MAC (Appeal Level 4), and:

- The decision is not completely favorable to you, or
- The decision tells you that the MAC decided not to review your appeal request.

How to file your appeal

To request judicial review of your case, you must file a civil action in a United States district court within 60 calendar days after the date you were notified of the decision made by the MAC (Appeal Level 4). The letter you receive from the MAC will tell you how to request this review, including who can file the appeal.

Your appeal request will not be reviewed by a Federal Court if the dollar value of the requested Medicare Plus Blue Group medical care or service does not meet the minimum requirement specified in the MAC's decision.

How soon will the Judge make a decision?

The Federal Court Judge will first decide whether to review your case. If it reviews your case, a decision will be made according to the rules established by the Federal judiciary.

If the Judge decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by a Federal Court Judge.

If the Judge decides against you:

You may have further appeal rights in the Federal Courts. Please refer to the Judge's decision for further information about your appeal rights.

Favorable Decisions by the ALJ, MAC, or a Federal Court Judge

This section explains what we must do if our initial decision denying what you asked for is reversed by the ALJ, MAC, or a Federal Court Judge.

For a decision about Medicare Plus Blue Group medical care or services, we must pay for, authorize, or provide the medical care or service you have asked for within 60 days of the date we receive the decision.

PART 2. Complaints (appeals) if you think you are being discharged from the hospital too soon

When you are admitted to the hospital, you have the right to receive all the hospital care covered by the plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your discharge date) is based on when your stay in the hospital is no longer medically necessary. This part explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

Within two days of admission as an inpatient or during pre-admission, someone at the hospital must give you a notice called the Important Message from Medicare (call Member Services at 888-322-5557 or 800-MEDICARE (800-633-4227) to receive a sample notice or see it online at **cms.hhs.gov/BNI**). This notice explains:

- Your right to receive all medically necessary hospital services paid for by the plan (except for any applicable co-payments or deductibles).
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and who will pay for them.
- Your right to receive services you need after you leave the hospital.
- Your right to appeal a discharge decision and have your hospital services paid for by us during the appeal (except for any applicable copayments or deductibles).

You (or your representative) will be asked to sign the Important Message from Medicare to show that you received and understood this notice. **Signing the notice does not mean that you agree that the coverage for your services should end – only that you received and understand the notice.** If the hospital gives you the Important Message from Medicare more than two days before your discharge day, it must give you a copy of your signed Important Message from Medicare before you are scheduled to be discharged.

Review of your hospital discharge by the Quality Improvement Organization

You have the right to request a review of your discharge. You may ask a Quality Improvement Organization to review whether you are being discharged too soon.

What is the "Quality Improvement Organization"?

"QIO stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of the plan or the hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In Michigan, the QIO is the Michigan Peer Review Organization. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

Getting the QIO to review your hospital discharge

You must quickly contact the QIO. The Important Message from Medicare gives the name and telephone number of the QIO and tells you what you must do.

- You must ask the QIO for a "**fast review**" of your discharge. This "fast review" is also called an "immediate review."
- You must request a review from the QIO no later than the day you are scheduled to be discharged from the hospital. **If you meet this deadline, you may stay in the hospital after your discharge date without paying for it while you wait to receive the decision from the QIO.**
- The QIO will look at your medical information provided to the QIO by the hospital and us.
- During this process, you will receive a notice giving our reasons why we believe your discharge date is medically appropriate.
- The QIO will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that is been set for you.

What happens if the QIO decides in your favor?

We will continue to cover your hospital stay (except for any applicable copayments, coinsurance, or deductibles) for as long as it is medically necessary and you have not exceeded our plan coverage limitations as described in Section 12.

What happens if the QIO agrees with the discharge?

You will not be responsible for paying the hospital charges until noon of the day after the QIO gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gives you its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If you remain in the hospital, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gave you its first decision.

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If the QIO agrees that your care should continue, we must pay for or reimburse you for any care you have received since the discharge date on the Important Message from Medicare, and provide you with inpatient care (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our plan coverage limitations as described in Section 12.

If the QIO upholds its original decision, you may be able to appeal its decision to an ALJ. Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds the decision, you may also be able to ask for a review by the MAC or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date, and provide you with inpatient care (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our plan coverage limitations as described in Section 12.

What if you do not ask the QIO for a review by the deadline?

If you do not ask the QIO for a fast review of your discharge by the deadline, you may ask us for a "fast appeal" of your discharge, which is discussed in Part 1 of this section. If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our plan coverage limitations as described in Section 12.
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date.
- If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our plan coverage limitations as described in Section 12.

PART 3. Complaints (appeals) if you think coverage for your skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) service is ending too soon

When you are a patient in a SNF, HHA, or CORF, you have the right to receive all the SNF, HHA or CORF care covered by the plan that is necessary to diagnose and treat your illness or injury. The day we end coverage for your SNF, HHA or CORF services is based on when these services are no longer medically necessary. This part explains what to do if you believe that coverage for your services is ending too soon.

Information you will receive during your SNF, HHA, or CORF stay

Your provider will give you written notice called the Notice of Medicare Non-Coverage at least two days before coverage for your services ends. Call Member Services at 888-322-5557 or 800-MEDICARE (800-633-4227) to receive a sample notice or see it online at **cms.hhs.gov/BNI/**. You (or your representative) will be asked to sign and date this notice to show that you received it. **Signing the notice does not mean that you agree that coverage for your services should end – only that you received and understood the notice.**

Receiving QIO review of our decision to end coverage

You have the right to appeal our decision to end coverage for your services. As explained in the notice you receive from your provider, you may ask the Quality Improvement Organization (QIO) to do an independent review of whether it is medically appropriate to end coverage for your services.

How soon do you have to ask for QIO review?

You must quickly contact the QIO. The written notice you got from your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you receive the notice two days before your coverage ends, you must contact the QIO no later than noon of the day after you receive the notice.
- If you receive the notice more than two days before your coverage ends, you must make your request no later than noon of the day before the date that your Medicare coverage ends.

What will happen during the QIO's review?

The QIO will ask why you believe coverage for the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review information that we have given to the QIO. During this process, you will receive a notice called the Detailed Explanation of Non-Coverage giving the reasons why we believe coverage for your services should end. Call Member Services 888-322-5557 or 800-MEDICARE (800-633-4227) to receive a sample notice or see it online at **cms.hhs.gov/BNI/**.

The QIO will make a decision within one full day after it receives all the information it needs.

What happens if the QIO decides in your favor?

We will continue to cover SNF, HHA or CORF services (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our plan coverage limitations as described in Section 12.

What happens if the QIO agrees that your coverage should end?

You will not be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the notice you receive from your provider. You may stop receiving services on or before the date given on the notice and avoid any possible financial liability. If you continue receiving services, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request.

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If the QIO agrees that your services should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our plan coverage limitations as described in Section 12.

If the QIO upholds its original decision, you may be able to appeal its decision to an ALJ. Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds our decision, you may also be able to ask for a review by the MAC or a Federal Court. If either the MAC or Federal Court agrees that your stay should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our plan coverage limitations as described in Section 12.

What if you do not ask the QIO for a review by the deadline?

If you do not ask the QIO for a review by the deadline, you may ask us for a fast appeal, which is discussed in Part 1 of this section.

If you ask us for a fast appeal of your coverage ending and you continue receiving services from the SNF, HHA, or CORF, you may have to pay for the care you receive after your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that coverage for your services should continue, we will continue to cover your SNF, HHA, or CORF services (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our plan coverage limitations as described in Section 12.
- If we decide that you should not have continued receiving services, we will not cover any services you received after the termination date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our plan coverage limitations as described in Section 12.

7. Discontinuing coverage

You can voluntarily cancel your State Health Plan PPO coverage or your dependent's coverage at any time by writing to the ORS. Include your signature and Social Security number. You may contact the Office of Retirement Services (ORS) at:

Office of Retirement Services
P.O. Box 30171
Lansing, MI 48909-7671
517-322-5103 or 800-381-5111

The cancellation effective date will be the last day of the month in which a premium (or dependent contribution) is paid.

In the event of divorce, the cancellation date is the date of the divorce.

Re-enrolling in Medicare Plus Blue Group plan

If you choose to re-enroll after you cancel your State of Michigan coverage, there is a six-month waiting period for coverage to take effect. Your coverage will begin six months following the first day of the month that ORS receives your application. Write to ORS at the address above.

Remember, contact the ORS promptly if your address changes.

8. Definitions of important words used in the EOC

Appeal – An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services or payment for services you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our plan does not pay for a service you think you should be able to receive. Section 6 explains appeals, including the process involved in making an appeal.

Benefit period – For both our plan and the original Medicare plan, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

The type of care that is covered depends on whether you are considered an inpatient for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 9 explains how to contact CMS.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed "copayment" amounts that a plan may require be paid when specific services are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a service.

Covered services – The general term we use in this EOC to mean all of the health care services and supplies that are covered by our plan.

Custodial care – Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are receiving in addition to daily skilled nursing care and/or skilled rehabilitation services.

Deductible – The amount you must pay for the health care services you receive before our plan begins to pay its share of your covered services.

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). Section 7 discusses disenrollment.

Durable medical equipment – Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment are wheelchairs, hospital beds, and equipment that supplies a person with oxygen.

Emergency care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Grievance – A type of complaint you make about us or one of our providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 5 for more information about grievances.

Home health aide – A home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home health care – Skilled nursing care and certain other health care services that you receive in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 12 under the heading "Home health care." If you need home health care services, our plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They are not covered unless they are not also receiving a covered skilled service. Home health services do not include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit **medicare.gov** and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits," or call 800-MEDICARE (800-633-4227).

Inpatient care – Health care that you receive when you are admitted to a hospital.

Medically necessary – Services or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) plan – A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (hospital) and Part B (medical) benefits. The State of Michigan's Medicare Advantage Plan is called Medicare Plus Blue Group.

"Medigap" (Medicare supplement insurance) policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in the original Medicare plan coverage. Medigap policies only work with the original Medicare plan. (A Medicare Advantage plan is not a Medigap policy.)

Member (member of our plan, or "plan member") – A person with Medicare who is eligible to receive covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 9 for information about how to contact Member Services.

Organization determination – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare plan – ("Traditional Medicare" or "Fee-for-service" Medicare) The original Medicare plan is the way many people receive their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance) and is available everywhere in the United States.

Medicare Plus Blue Group – see "Medicare Advantage (MA) plan"

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Section 9 for information about how to contact the QIO in your state and Section 6 for information about making complaints to the QIO.

Rehabilitation services – These services include physical therapy, speech and language therapy, and occupational therapy.

Skilled nursing facility (SNF) care – A level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people who are disabled, blind, or age 65 and older with limited income and resources. SSI benefits are not the same as Social Security benefits.

Urgently needed care – Section 3 explains about "urgently needed" services. These are different from emergency services.

9. Helpful phone numbers and resources

Contact Information for our plan

If you have any questions or concerns, please call or write to our plan Member Services. We will be happy to help you.

CALL 888-322-5557 Calls to this number are free.
Monday through Friday, 8:30 a.m. to 5:00 p.m.

TTY 800-579-0235 This number requires special telephone equipment. Calls to this number are free.

WRITE Medicare Plus Blue Group
600 E. Lafayette Blvd. – Mail Code X508
Detroit, MI 48226-2998

WEB SITE **bcbsm.com/medicare**

Contact information for grievances, organization determinations, coverage determinations and appeals

Medicare Plus Blue Group organization determinations (about your Medical Care and Services)

CALL 888-322-5557 Calls to this number are free.

TTY 800-579-0235 This number requires special telephone equipment.

WRITE Medicare Plus Blue Group
600 E. Lafayette Blvd. – Mail Code X508
Detroit, MI 48226-2998

Medicare Plus Blue Group Grievances and Appeals (about your Medical Care and Services)

CALL 888-322-5557 Calls to this number are free.

TTY 800-579-0235 This number requires special telephone equipment.

FAX 877-894-9531

WRITE BCBSM Medicare Advantage
Grievance Dept.
600 E. Lafayette Blvd. Mail Code X509
Detroit, MI 48226-2998

Medical Care Manager
BCBSM Medicare Advantage
600 E. Lafayette Blvd. – Mail Code H404
Detroit, MI 48226-2998

For information about Medicare Plus Blue Group grievances, see Section 5.

Other important contacts

Below is a list of other important contacts. For the most up-to-date contact information, check your *Medicare & You Handbook*, visit **medicare.gov** and choose "Search Tools" by selecting "Find Helpful Phone Numbers and Web sites," or call 800-Medicare (800-633-4227).

Medicare/Medicaid Assistance Program of Michigan (MMAP)

MMAP is a state organization paid by the federal government to give free health insurance information and help to people with Medicare.

Contact MMAP at:

Michigan Medicare/Medicaid Assistance Program
6105 W. St. Joseph, Suite 204
Lansing, MI 48917-4850
800-803-7174

You may also find the Web site for MMAP at **medicare.gov** under "Search Tools" by selecting "Find Helpful Phone Numbers and Web sites."

Michigan Peer Review Organization

The Michigan Peer Review Organization, supported by a federal organization, is a group of doctors and health professionals who review medical care and handle certain types of complaints from patients with Medicare. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon.

Contact MPRO at:

MPRO
22670 Haggerty Road – Suite 100
Farmington Hills, MI 48335-2611
800-365-5899 or 248-465-7300 Monday through Friday, from 8:00 a.m. to 4:00 p.m. EST.
Fax: 248-465-7428
E-mail MPRO at: medicarehotline@mpro.org

How to contact the Medicare program

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). Our organization contracts with the federal government.

- Call 800-MEDICARE (800-633-4227) to ask questions or receive free information booklets from Medicare 24 hours a day, 7 days a week. Customer service representatives are available 24 hours a day, including weekends.
- Visit **medicare.gov** for information. This is the official government Web site for Medicare. This Web site gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage plans and Medicare Prescription Drug plans in your area. You can also search under "Search Tools" for Medicare contacts in your state. Select "Helpful Phone Numbers and Websites." If you do not have a computer, your local library or senior center may be able to help you visit this Web site using its computer.

Medicaid

Medicaid is a state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify.

To find out more about Medicaid and its programs, contact Medicaid Helpline for recipients at 800-642-3195, Monday through Friday, 8 a.m. to 7 p.m. EST (also available in Spanish and Arabic). Michigan Department of Community Health, Medical Services Administration, 400 S. Pine St., Lansing, MI 48933, or go to: **michigan.gov/mdch**.

Social Security

Social Security programs include retirement benefits, disability benefits, family benefits, survivors' benefits, and benefits for the aged and blind. You may call Social Security at 800-772-1213. TTY users should call 800-325-0778. You may also visit **www.ssa.gov** on the Web.

Railroad Retirement Board

If you receive benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board Helpline office at 800-808-0772. You may also visit **www.rrb.gov** on the Web.

10. Legal notices

Notice about governing law

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

Notice about nondiscrimination

We do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive Federal funding, and any other laws and rules that apply for any other reason.

11. How much you pay for your Medicare Plus Blue Group medical benefits

Our plan is a Medicare Advantage Private-Fee-for-Service plan. A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions of payment, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions of payment, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions of payment on our Web site at: **bcbsm.com/ma**.

How much you pay for Medicare Plus Blue Group medical benefits

This section has a benefits chart that gives a list of your covered services and tells what you must pay for each covered service. These are the benefits and coverage you receive as a member of our plan. Later in this section under "General Exclusions" you can find information about services that are not covered. It also tells about limitations on certain services. This section supplements Your Benefit Guide that summarizes your health care benefits. If this section conflicts with Your Benefit Guide in any manner, this section will govern.

What do you pay for covered services?

Deductibles, copayments, and coinsurance are the amounts you pay for covered services.

- The "**deductible**" is the amount you must pay for the health care services you receive before our plan begins to pay its share of your covered services.
- A "**copayment**" is a payment you make for your share of the cost of certain covered services you receive. A copayment is a set amount per service. You pay it when you receive the service.
- "**Coinsurance**" is a payment you make for your share of the cost of certain covered services you receive. Coinsurance is a percentage of the cost of the service. You pay your coinsurance when you receive the service.

What is the maximum amount you will pay for covered medical services?

There is a limit to how much you have to pay out-of-pocket for certain covered health care services each year. When your coinsurance payments equal $1,000 in a calendar year, you have reached your coinsurance maximum out-of-pocket payment, and will not have to pay a coinsurance for the remainder of the year for covered services.

Certain charges cannot be used to meet your out-of-pocket maximum. They include:

- Deductibles
- Copayments (fixed dollar amounts)
- Private duty nursing coinsurance
- Charges for noncovered services
- Charges in excess of our approved amount
- Deductibles, copayments or coinsurances required under other BCBSM coverage

12. Benefits chart

The benefits chart on the following pages lists the services our plan covers and what you pay for each service. The covered services listed in the benefits chart in this section are covered only when all requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered.

The benefits chart is provided as a summary only and does not include all covered and non-covered services.

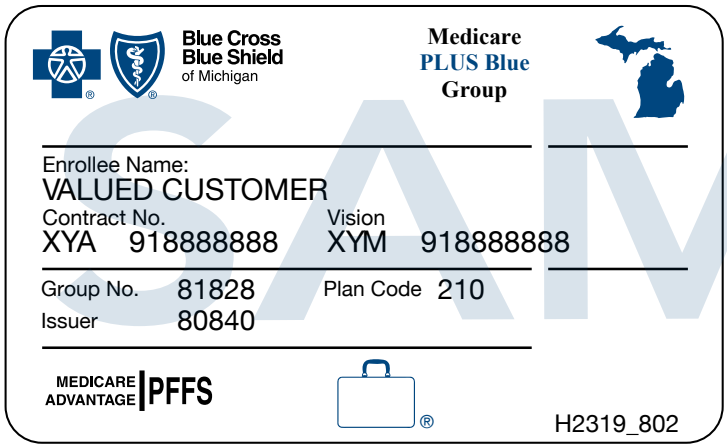
See Section 3 for information on requirements for using providers.

Your health coverage	What you pay
Inpatient services	
Inpatient hospital care	Deductible
Inpatient mental health care/substance abuse	$0
Skilled nursing facility care	Deductible
Surgery	Deductible
Outpatient services	
Ambulance services	Deductible
Emergency care	$0
Outpatient cardiac rehabilitation	Deductible
Outpatient diagnostic tests and therapeutic services	Deductible
Outpatient mental health/substance abuse	10%
Outpatient physical, occupational and speech therapy	Deductible
Outpatient surgery	Deductible
Physician office services	
Chiropractic manipulation	10% after deductible
Chiropractic office visits	$10
Office visits, consultations, and urgent care visits	$10
Outpatient and home visits	$10
Diagnostic services	
Clinical laboratory services	$0
Imaging services, includes X-rays, CAT, PET, MRI scans	Deductible
Laboratory and pathology services (excluded clinical laboratory services)	Deductible

Your health coverage	What you pay
Alternatives to hospital care	
Home health care	$0
Hospice	$0
Private duty nursing	10% after deductible
Preventive care services	
Bone-mass measurements	$0
Cardiovascular screening	$0
Colorectal screening • Fecal occult blood test • Barium enema • Colonoscopy • Flexible sigmoidoscopy	$0
Diabetes screenings	$0
Flu shots – covered once annually	$0
Glaucoma tests – once annually if high risk	$0
Hepatitis B shots	$0
Mammography screening	$0
Pap tests, pelvic exams, a clinical breast exam	$0
Physical exams	$0
Prostate cancer screening exams	$0
Pneumococcal – once in a lifetime	$0
Other medical services	
Allergy testing and treatment	Deductible
Blood and blood products	Deductible
Chemotherapy services	Deductible
Dental services (due to injury)	Deductible
Durable medical equipment and medical supplies	$0
Hearing aids	$0
Medical hearing exam	$10
Medical eye exam	$10
Prosthetic and orthotic appliances	$0

Sample plan membership card

Here is an example of what your plan membership card looks like. See Section 1 for more information on using your plan membership card.



Explanation of Benefits

You will receive an Explanation of Benefits (EOB) form each time a claims is processed under your contract number. The EOB is not a bill. It is a statement that helps you understand how your benefits were paid.

Please check your EOB carefully. If you see an error, please contact your provider first. If they cannot correct the error, call Member Services at 888-322-5557. Customer service representatives are available 8:30 a.m. to 5:00 p.m. Monday through Friday.

General exclusions

Introduction

The purpose of this part of Section 12 is to tell you about medical care and services, and items that are not covered ("are excluded") or are limited by our plan. The list below tells about these exclusions and limitations. The list describes services and items, that are not covered under any conditions, and some services that are covered only under specific conditions. (The benefits chart earlier also explains about some restrictions or limitations that apply to certain services).

If you receive services or items that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the original Medicare plan, unless they are found upon appeal to be services or items that we should have paid or covered (appeals are discussed in Section 6).

What services are not covered or are limited by our plan?

In addition to any exclusions or limitations described in the benefits chart, or anywhere else in this EOC, **the following items and services are not covered under the original Medicare plan or by our plan**:

1. Services that are not reasonable and necessary, according to the standards of the original Medicare plan, unless these services are otherwise listed by our plan as a covered service
2. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the original Medicare plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare & Medicaid Services (CMS) will continue to pay through original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan members. Experimental procedures and items are those items and procedures determined by our plan and the original Medicare plan not to be generally accepted by the medical community.
3. Surgical treatment of morbid obesity unless medically necessary and covered under the original Medicare plan
4. Private room in a hospital, unless medically necessary
5. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility
6. Nursing care on a full-time basis in your home
7. Custodial care unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
8. Homemaker services
9. Charges imposed by immediate relatives or members of your household.
10. Meals delivered to your home.
11. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary

12. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy as well as for the unaffected breast to produce a symmetrical appearance.
13. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. However, non-routine dental services received at a hospital may be covered.
14. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
15. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the brace. Exception: therapeutic shoes are covered for people with diabetic foot disease.
16. Supportive devices for the feet Exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
17. Eyeglasses (except after cataract surgery), routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
18. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
19. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
20. Naturopath services.
21. Services provided to veterans in Veterans Affairs facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our plan, we will reimburse veterans for the difference. Members are still responsible for our plan cost-sharing amount.
22. Any of the services listed above that are not covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

Notes

Blue Cross Blue Shield of Michigan
Medicare Plus Blue Group — Mail Code B491
600 East Lafayette Blvd.
Detroit, Michigan 48226-2998
RETURN SERVICE REQUESTED

www.bcbsm.com/ma

Medicare PLUS Blue Group℠

Blue Cross
Blue Shield
of Michigan

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association